

# Disease State Management Of Diabetes Program

## A Collaborative Health Care Approach

Prepared by:

The ND Pharmacy Service Corporation in collaboration with, the ND  
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# Disease State Management Of Diabetes Program

**Mission:** The mission of the North Dakota Pharmacists Association Disease State Management program for Diabetes is to empower and educate patients with diabetes mellitus to develop and improve self-management skills in order to improve quality of life, and to reduce complications.

**Goal:** Our goal is to provide an integral component of diabetes care using the National Standards for Diabetes Self-Management Education thru certified pharmacists, or other certified health care professionals, as determined by the NDPhA.

**Guidelines:** This program will consist of an established system including a coordinator and advisory board. The coordinator will oversee the planning, implementation and evaluation of the program. The coordinator and advisory board will participate annually in a planning and review process of the program. A continuous quality improvement process will be used to evaluate the effectiveness of the program and determine opportunities for improvement. Our target population will be patients with diabetes mellitus currently obtaining health care coverage through their employer. Our statewide network of certified pharmacists and other certified health care providers would obtain regular continuing education in the areas of diabetes management as required by certification. A standardized written curriculum shall be used by, all participating providers to provide successful learning outcomes. The program will include documentation of patient assessment, planning, and evaluation. Outcomes data will be collected using electronic means of data collection.

## **Project Overview**

An essential ingredient that has been missing from the health care delivery system is the active participation of the patient, who is key to achieving desired outcomes in care. When patients are engaged, empowered, and understand their role, they become more active, knowledgeable, and capable of achieving improvements in their overall care. Employers are always looking at ways to decrease their overall health care costs, to reduce employee's medical appointments (absenteeism), and to create happier/healthier employees. Individuals with chronic conditions can account for more than 50% of an employer's health care costs. We need to look at health care as an investment in one's well being compared to an expense for sickness. The ND Pharmacy Service Corporation (NDPSC) wants to help promote better health and social advancement and to reduce medical costs for individuals with diabetes and their employer(s) through a program called Disease State Management of Diabetes.

During the 2007 ND Legislative session, House Bill 1433 passed and was signed by the Governor. House Bill 1433 allows pharmacists and other qualified North Dakota health care providers to provide Disease State Management (DSM) to North Dakota public employees that suffer from chronic diseases and specifically have diabetes. The North Dakota Pharmacy Service Corporation wants to offer a disease state management program of diabetes. The intent of this program, as it relates to House Bill 1433, is to deliver services and support to individuals (NDPERS members) that have a chronic disease identified as diabetes (Type 1 or Type 2). By implementing a program of this nature, NDPSC will increase access to health care, redefine how services are delivered, increase the participant's knowledge base regarding their disease, increase the quality of life for participants, improve overall health status and medication adherence for their participants, and reduce health care costs on multiple levels for numerous interest groups.

The practice model is designed to bring about a high level of collaborative care by increasing the communications among patients, pharmacists, physicians, nutritionists and other health care providers. Enhanced communications promotes sharing of pertinent clinical data, including the objective measures obtained in the pharmacy, and the

facilitation of evaluation of patient's progress towards clinical goals and adjustments in the patient's treatment plans.

Because of the success of the "Asheville Project" and other collaborative care programs involving pharmacists, interest has increased in developing a model that can be replicated and scaled up in diverse communities, payer settings, and that would have the capacity to transform the health care system, improve diabetes outcomes and control costs. Pharmaceutical care services will be provided by a network of pharmacists and other providers who have completed an accredited diabetes certification program and they will "coach" patients on how to self-manage their diabetes.

### **Scope of Work**

(Goals, Objectives and Activities-Methodology)

#### **Goal # 1 – Provider Network Training and Accreditation**

The first goal of the program is to establish a statewide diabetes network of trained certified providers. The network will consist of pharmacists, certified diabetes educators, and other appropriate health care providers with oversight of the network being provided by a Clinical Coordinator and a Peer Review Board.

#### **Objective # 1**

A network of trained certified providers will be created with oversight being provided by a Clinical Coordinator and a Peer Review Board.

#### **Activity # 1**

A co-license agreement will be sought between NDSU College of Pharmacy, ND Pharmacy Service Corporation (NDPSC) and the National Institute of Pharmacists Care Outcomes (NIPCO) for training and certification purposes. The training and certification process will be conducted by, the NDSU College of Pharmacy, Nursing and Allied Sciences with Dr. Tara Schmitz, Pharm. D. taking the lead role in collaboration with the Clinical Coordinator. Training and accreditation of providers is to be completed prior to May 2008. Network providers will also be trained on how to develop a plan for implementing such a program in their practice setting and will also learn to develop a

“patient-centered” self-management planning model using American Diabetes Association materials and other appropriate means.

By gathering claims data from Blue Cross Blue Shield of North Dakota, participants will be identified by location, so we can develop a network around the greatest need to begin with. A provider network database will be created monitored and updated. Provider commitments have already been made by a number of pharmacies. All network providers will be required to sign a “network agreement” document that will outline their role and responsibilities as a provider. A Clinical Coordinator will be hired no later than March 1, 2008 to provide coordination, general oversight, and to fill in any possible “gaps” in service. A Peer Review Board will be established with 4-6 practitioners of the specialty. Each network provider will be required to take a minimum of 6 hours of related CE per year. The Peer Review Board will also serve as the peer review committee for continuing competence. After initial certification has been issued, there will be a requirement for renewal. Some of the requirements for renewal may include the following; (1) renewal required every 2 years, due 90 days before expiration, (2) six hours of ACPE approved related CE required each year, (3) submit a summary of diabetes therapy management activities performed over the previous 20 months, (4) state number of patients served and number of practitioners with whom you have collaborated, along with 1 physician whom the committee can contact, and (5) submit 2 care plans, and outcomes data for patients seen during this 2-year period for committee review.

The Review Committee will issue a renewal card for display with the original certificate. Renewal cards will be mailed out by, the ND Pharmacists Association. The work of the review committee is allowable under HIPPA. If you are not actively seeing patients, you must retake the training course

## **Goal # 2 – Provider Network Training - Additional**

The second goal is to make sure that each provider in the network is trained on how to use the same blood glucose monitor and software application. In addition, each provider will be trained on how to access and use the same web-based data management software documentation system.

**Objective # 2**

A supplier will provide identical blood glucose monitors for participating providers and will provide training on how to use the monitors and the application for such monitors. In addition, a data management documentation system will be identified to provide data collection and training to providers on such a system.

**Activity # 2**

Entities will be contacted to possibly provide identical blood glucose monitors and training associated with the devices (i.e. Life Scan). Training sites will be established statewide for network providers. A contract will be executed prior to March 1, 2008 with a valid data management documentation system (i.e. Medication Management Systems). MMS will provide training sites to educate network providers on how to access and use the common web-based system. We have not entered into a contract with MMS yet, but anticipate doing such in the near future. The training will be organized by the Clinical Coordinator and will be conducted prior to seeing program participants and in conjunction with blood glucose monitor training, if feasible.

**Goal # 3 – Program Promotion and Enrollment**

The third goal of the program is to send program notification out to eligible participants, start enrolling and seeing participants. The development of a “communication” network will be established.

**Objective # 3**

A formal letter will be developed and mailed, notifying eligible participants of the program, its services and incentives. Enrollment and provider services will begin no later than July 1, 2008. Clinical Coordinator will establish a communication network or central communication hub.

**Activity # 3**

Example letters used in the Asheville Project will be used appropriately. A letter notifying participants of the project, its services and incentives will be issued by, the ND Public Employees Retirement System in collaboration with the ND Pharmacy Service

Corporation. NDPERS will decide on how to officially promote or advertise the program. Enrollment will begin no later than July 1, 2008. Participant non-compliance policy will also be used just as in the Asheville Project. NDPERS and the data management system will collaborate with Blue Cross Blue Shield of North Dakota regarding the identification of participants for related waived co-pays once enrolled. Being able to waiver co-pays at the “point-of-sale” would be ideal. Participants will be able to choose which network provider they want to access. If a network provider is not available, the Clinical Coordinator will review possible options with participant. Clinical Coordinator may provide on-site visits at a central location that is accessible and feasible for the participant. Network providers will begin seeing participants no later than July 1, 2008. Clinical Coordinator will establish a “communication network” among project participants, NDPSC, NDPERS, BC/BS of ND, Prime, physicians, and the “provider network.” The establishment of a communication network will be accomplished prior to July 1, 2008.

#### **Goal # 4 – Clinical, Humanistic and Economic Measures – Data Management Plan**

A fourth goal of this program is to collect clinical indicators, humanistic measures and economic data for statistical analysis.

#### **Objective # 4**

Using a common data management system, all network providers will collect the same data, and use the same evaluation form(s). The Clinical Coordinator will ensure all information is collected and recorded appropriately while accessing the online data software system.

#### **Activity # 4**

The data management system will be web-based and accessible anywhere there is Internet access. All providers that have previously received training on how to access and use the system will begin entering the same data for consistency and accuracy. A contract will be executed prior to March 1, 2008 with Medication Management Systems of Minneapolis, MN. Parameters will be collected including hemoglobin A1C as the primary clinical outcome. Hemoglobin A1C collected at baseline and every 6 months.

Secondary outcomes to be collected include lipid panel (HDL, LDL) at baseline and each subsequent visit. Other measures to be tracked and recorded include but not limited to weight, smoking, depression, diet, exercise, testing of blood sugars at home and ACE inhibitor use. Annual foot and eye exams will be recommended and problems will be referred to the appropriate professional. The Asheville Project will be used as a model and American Diabetes Association materials and research will be used as a guide when looking for targeted outcomes. A Diabetes Quality of Life (DQOL) questionnaire will be developed using American Diabetes Association and Asheville Project materials as a guide. DQOL will be conducted 12 months after entering the program. At a minimum, the following economic data will be collected: (1) medical claims history; (2) diabetes related medications; and (3) non-diabetes related medications. Pre-post analysis will be conducted based on claims data going back at least 12 months prior to the start of the program and 12 months after enrollment.

Statistical Analysis: Assessment measures (A1C, lipid panels, blood pressures, weight, smoking and others) will be documented and entered into a web-based documentation system and transferred to a SAS database for analysis. DQOL will be scored based on published criteria. The Chi-square test of independence will be used to assess similarity in demographics of both groups. Intervention groups at 12 months will be compared to baseline measures using the General Linear Model (GLM) procedure (one-way ANOVA) and t-tests (A1C levels). An alpha level of .05 will be used. The web-based documentation system will be used by, all pharmacists participating in the project for consistency, accuracy and efficiency. Dr. David Scott (Associate Professor of Pharmacy Practice and Director of the ND Institute for Pharmaceutical Care at the NDSU College of Pharmacy) and Charles Peterson (Dean – College of Pharmacy, Nursing and Allied Sciences) have offered to complete the analysis of the data collected and report significant findings. Medication Management Systems can generate reports daily, weekly, monthly, quarterly, or yearly. At a minimum, reports will be generated every 12 months. Please see **Attachment C** for a list of possible reports to be generated. The employer has the ability to decide if they would like additional reports to be generated.



### **Goal # 5 – Advisory Board**

An Advisory Board will be established to monitor and access the whole program moving forward.

### **Objective # 5**

The establishment of an Advisory Board will be completed prior to July 1, 2008.

### **Activity # 5**

The Advisory Board will consist of members appointed by the ND Pharmacy Service Corporation. Members may be included from the following: (1) ND Pharmacists Association; (2) ND Pharmacy Service Corporation; (3) ND Society of Health System Pharmacists; (4) NDPERS; (5) BC/BS of ND; (6) NSDU College of Pharmacy; (7) ND Board of Pharmacy; ND Diabetes Coalition; (8) ND Department of Health; and (9) Legislator(s).

### **Goal # 6 – Yearly Reports**

Year-end report will be developed.

### **Objective # 6**

Data that has been collected will be gathered and examined.

### **Activity # 6**

NDSU College of Pharmacy has offered to assist in the process of gathering data, analyzing and reporting of findings or NDPERS has expressed interest in issuing an RFP to accomplish this identified goal. One-year Report (12-month prior comparison with 12-month enrollment period) will be completed prior to September 2009. Please see Attachment C for a list of possible reports to be generated for analysis. Reports can be generated daily, weekly, monthly, quarterly and/or yearly. The employer can decide how frequently reports are to be generated.

### **Goal # 7 – Expansion into 2<sup>nd</sup> year**

The fifth goal of this program is to utilize the ND NDSU Telepharmacy Network and the utilization of NDSU pharmacy students.

**Objective # 7**

During the last quarter of 1<sup>st</sup> program year or at the end of the 1<sup>st</sup> year, the utilization of the ND NDSU Telepharmacy Network will be implemented and students at the NDSU College of Pharmacy will begin contributing to the Disease State Management of Diabetes – A Collaborative Health Care Approach Program.

**Activity # 7**

Students in the Concept Pharmacy Laboratory at NDSU College of Pharmacy will connect to remote telepharmacy sites across the state through the telepharmacy technology (audio and video link) to provide patient education counseling services to the identified pharmacies, to provide drug information to the practicing pharmacies serving patients, and to participate in drug therapy monitoring and disease state management of diabetes patients.

Students will also have an opportunity to participate in on-site patient education counseling, drug therapy monitoring and disease state management activities through clinical rotations at the established pharmacies throughout the state as part of the student's experiential program of study. Students will also be trained and certified in diabetes care as part of their experiential program of study.

**Goal # 8 – Expansion into 2nd year**

The sixth goal of this program is to establish a patient “peer-to-peer” mentoring program.

**Objective # 8**

During the second year of the program, a patient “peer-to-peer” mentoring program will be implemented.

**Activity # 8**

In order to create sustainable behavior changes in individuals with diabetes, a peer-to-peer mentoring program will be created. It is believed that patient outcomes will improve through community-based interactions and interventions. This is a great cost

effective supportive care model for individuals with diabetes. Launched by the American Academy of Family Physicians Foundation, Peers for Progress is in the process of developing a peer-to-peer mentoring model that can be replicated in various environments. We will look to Peers for Progress for their expertise and guidance in developing our own peer-mentoring network. Funding for this effort may be made available through Peers for Progress during 2008. A peer-mentoring network will be developed with expectations of having peer mentors in each of our Districts that we serve to start with. We have already started discussions with Peers for Progress and their Executive Director, Larry Ellingson R.Ph.

### **Participant Eligibility and Responsibilities**

According to the North Dakota Public Employees Retirement System (NDPERS), the defined population is estimated to exceed 2,300 diagnosed diabetics and it is estimated that this program will support an educational and therapeutic intervention for approximately 800 individuals. NDPERS expects that most of the participants will be centered around the Fargo, Bismarck, Minot, Grand Forks, and Dickinson areas. A concerted effort will be made to develop a network of providers that can address the needs of participants living in rural North Dakota, as well as urban. Our network will try to serve as many participants in the community of their choice whenever possible. To be eligible for this program, participants have to be a current NDPERS member and have a diagnosis of diabetes type 1 or type 2. The NDPERS group will be sending out information to all eligible participants regarding the availability of this program and the services and incentives of the program.

All participants will be required to give written consent once they are informed of the pertinent background information of the program, what their participation involves (including potential risks, benefits, inconveniences, discomforts, etc...), their right to confidentiality and right to withdraw at any time. After signing an informed consent form, an enrollment form to participate, and an authorization for medical information to be sent to the pharmacist by other health care providers, the participant will be enrolled

and assigned a patient code. The provider network will allow the participant to choose which provider they want to use or the provider network will assign participants to an appropriate provider (local participating pharmacist or other appropriate health care professional), if no preference is desired.

The implementation of a patient self-management training and assessment program will be addressed and implemented. Successful completion will equip participants with the knowledge and skills to actively manage their diabetes away from the healthcare practice setting. A patient-centered planning model will be used (the participant lives 24-7 with their disease and are the key to their own success) for the delivery of services and support, including goal setting. The planning and delivery of services will be implemented in accordance with each participant's unique needs, expressed preferences, limitations, and resources available. Environmental issues and/or concerns will also be addressed, when appropriate.

The program will consist of interventions and education conducted through scheduled appointments. The structured visits will focus on knowledge, skills and performance of the patient participating in the program. Nutrition, depression, exercise, weight, and medication compliance will be addressed during this process as well. A typical participant may experience the following: 1) start with an initial (baseline) appointment, that is scheduled for one hour, that consists of making sure the proper paperwork is completed, 2) check the participants history, blood pressure, weight, diet, medication history and compliance with medications and glucose monitoring equipment, 3) an educational plan (person-centered) and goals will be established that identify one or more diabetes related goals to work on, 4) referral for an A1C level and lipid panel, and 5) the pharmacist entering pertinent information into a common web-based documentation system.

Each follow-up appointment (approx 30 minutes) will focus on disease management, (1) accessing participant compliance with diet, medication regimen, and monitoring outcomes identified, (2) follow-up on education and (3) goal setting. Follow-up appointments may be scheduled at 14 to 28 days, and 30 to 45 days and 6, 9, and 12 months the first year. During the second year, follow-up visits may be scheduled at 15, 18, 21, and 24 months. Using and entering pertinent information on the web-based

documentation system will be done for all appointments. The overall impact is to create a positive patient relationship, ensure follow-up, and provide pharmacotherapy interventions to reach American Diabetes Association standards of care and goal setting. Throughout the program appropriate referrals, will be made by the pharmacist to physicians and other professional health care providers.

Participants will receive incentives that are created to increase motivation and participation. Participants will receive waived co-payments for diabetes related medications and supplies (possibly free glucose monitor and refillable blood glucose strips) for health plan members who fulfill their responsibilities while in the program. Participants not adhering to goals that were established and/or not keeping appointments will be notified and continued non-compliance will cause the participant to be ineligible for the program and the benefits of the program. Pharmacist will notify the participant and the NDPERS of non-compliance issues and the participant will no longer be eligible for services and incentives of the program.

**Patient Commitment/responsibilities:**

- Patient participation is voluntary. Patients can choose to enroll in the program or drop from the program at any time. If they drop out or fail to cooperate with program elements, the financial incentives will be stopped.
- Agree to provide baseline health status information, complete quality of life survey, consent form and other appropriate documents.
- Agree to baseline and follow-up laboratory and physical assessment evaluation.
- Agree to attend educational classes, when appropriate.
- Agree to work on established goals set.
- Agree to obtain all medication history from a participating pharmacy so that the pharmacist has a complete record of all medications, and agrees to discuss OTC data with the pharmacist. Exceptions are made in the time of an emergency or other extenuating situations.

- Will indicate pharmacy location preferences from a list of trained pharmacists. The program will attempt to match the patients with a pharmacy location that is most convenient for them.
- Agree to meet the pharmacist or other provider for follow-up visits. These sessions will be scheduled at a time that is convenient for both the patient and the pharmacist, and can be expected to last about 30 minutes each appointment.

### **Pharmacist Education and Standards of Care**

Many of our pharmacists are the first primary care providers patients see and are extremely accessible. The 2006 Medicare Prescription Drug Benefit (Plan D) and Medication Therapy Management (MTM) services support the pharmacist's recognition and payment for pharmacist-provided DSM services. The NDPERS diabetes program also recognizes the pharmacist's expanding role into DSM of chronic health conditions in North Dakota.

Pharmacist's responsibilities have evolved from the traditional dispensing of medications to an expanded patient-oriented profession known as pharmaceutical care. Studies conducted over the last two decades have confirmed the effectiveness of pharmacists' clinical services in helping to assure the safe, effective, and cost-conscious use of medications. These studies suggests that for every \$1 invested in clinical pharmacy services, nearly \$17 is saved in the form of reduced medication expenditures associated with a reduction in drug-related morbidity.<sup>3</sup> Two pharmaceutical care studies include Project ImPACT and the Asheville Project. Project ImPACT (Improve Persistence and Compliance with Therapy) included 26 ambulatory care pharmacists that managed patients with lipid disorders requiring pharmacological intervention. During this three-year project, observed rate of compliance with lipid-lowering drug therapy improved to about 90%, and nearly two-thirds of participants maintained accepted treatment goals.<sup>4</sup>

Pharmacists will take an initial course of diabetes study, followed by training sessions regarding diabetes management. Validated materials [National Institute for Pharmacist Care Outcomes (NIPCO), (<http://www.ncpanet.org/nipco/index.php>)<sup>5</sup> and

American Association of Diabetes Educators (ADA)] materials <sup>6</sup> will be used in the training program on diabetes.

Launched by the National Pharmacists Association (NCPA) in 1995, NIPCO is the national accrediting organization for pharmacist care education and training programs leading to the pharmacist care Diplomat credential and a leading authority in helping pharmacists develop new market niches focused on patient care services. This program can be applied toward the attainment of the [NIPCO Pharmacist Care Diplomat Credential](#) and will provide participants with 16 to 20 ACPE CE contact hours (1.6 to 2.0 CEUs) of continuing education, and is available in both live and home study formats.

This course focuses on how to help patients better understand and manage a complex and chronic condition—diabetes. The pharmacist will become familiar with the disease characteristics of diabetes, methods of treatment ranging from diet to medication, and techniques for helping patients manage their disease. Topics include: physiology and pathophysiology, clinical management, diet and nutrition, psychosocial assessment and management, contemporary issues in diabetes care, and utilization of online data collection services. Participants will learn how to develop a diabetes care center in their pharmacy.

#### Professional Competencies

- Define and contrast type 1 and type 2 diabetes.
- Describe key educational issues associated with each therapeutic agent.
- List six important educational areas in teaching self glucose monitoring and demonstrate a glucose measurement method.
- List the identification, treatment and prevention of hypoglycemia and hyperglycemia.
- Demonstrate how to document the essential components of a diabetes care plan and billing methods for pharmacist care of patients with diabetes.
- Demonstrate how to teach the proper technique for drawing and injecting insulin.
- Relate the state and federal regulations pertaining to community pharmacy-based whole blood technology testing and screening procedures, e.g., OSHA, CLIA.
- Discuss the nutritional recommendations of the American Diabetes Association.
- Explain the importance of patient education issues related to diabetes and exercise, illness and hypoglycemia.
- Discuss the emotional, social and financial barriers to adherence with diabetes.

A curriculum obtained through a co-licensing agreement with NIPCO will be used for training of pharmacists through home-based study to learn therapeutics and a 2-

day seminar and clinical skills lab. To accomplish this objective, the following action steps will be taken.

1. Through self-study (12 hours), pharmacists will complete a therapeutic diabetes module and pass a competency-based examination (minimum score of 70%) prior to on-site training.
2. Through a 2-day seminar and clinical skills lab (16 hours), pharmacists will enhance their DSM skills in developing collaborative practice agreements with local providers, documenting patient interventions, and drug information **(Attachment A)**.
3. Each pharmacist will write a strategic (action) plan to implement DSM in their pharmacy setting. Before finishing the training, each pharmacist will be requested to complete a diabetes action plan for their setting based upon how this program can be adapted to his/her setting.<sup>2</sup> Action plan components to be included are the needs' assessment, marketing of the plan to physicians and patients, workflow changes incorporating technicians, proposed design changes, and an assessment plan.

Provider/Patient Initial Assessment (typical baseline): Patients will be monitored frequently by, specially trained providers, who have completed training and agree to the following minimum program protocol.

- Pharmacist to complete data documentation software.
- Check patient's blood pressure at least two times at rest (at least 30 minutes after caffeine ingestion or nicotine product use).
- Weight the patient.
- Review any previously established educational/self-monitoring goals the patient may have.
- Identify one to three diabetes-related goals for the patient to work on until the next visit.
- Review definitions, benefits, and components of "good control."
- Determine if patient is aware of physician treatment goals for them (blood sugar, weight loss, monitoring frequency, etc...)
- If unaware, educate the patient on general American Diabetes Association goals. Contact primary care provider if additional intervention is needed or requested.
- Determine glucose meter needs and frequency of use.
- Download glucose meter as needed and analyze control pattern for potential problems.
- Review medication history including over-the-counter and complimentary or alternative medication use.
- Assess patient understanding of medication, diet, and monitoring regimen.
- Assess compliance with medications, diet, and monitoring.



- Assess for side effects/adverse reactions to medications.
- Assure that the patient understands when to seek physical or emergency care.
- Complete “SOAP: note (Subjective, Objective, Assessment, Plan) or “FARM” note (Findings, Assessment, Recommendations, Monitoring).
- Communicate pertinent patient encounter information/findings to primary care provider.

#### Follow-up Sessions with Patients:

- Pharmacists to complete follow-up records using data documentation system.
- Check patient’s blood pressure at least two times at rest (at least 30 minutes after caffeine ingestion or nicotine product use).
- Weight patient.
- Review American Diabetes Association standards of diabetes care or equivalent.
- Review definitions, benefits, and components of “good control.”
- Follow-up on education plan and goals. Assist patient in establishing new goals, as needed, using ADA guidelines or equivalent.
- Provide educational material to supplement counseling (tailored to each individual patient).
- At every opportunity reinforce the physician’s treatment plan and when necessary request the initiation of individualized goals by the physician.
- Refer patients with significant findings to their primary physician.
- Refer patients who are consistently failing to make progress toward goals to their primary care provider.
- Refer patients to certified diabetes educators, if assessment indicates patient needs a more focused educational intervention.
- Cover self-monitoring blood glucose testing again– what it is, what it can do for them.
- If patient chooses to begin self-managed blood glucose (SMBG) testing, providers will train patient. If patient is already performing SMBG testing, provider will check and download meter readings, reinforce testing techniques, and inform physician of any undesirable trends that are noted.
- Assess patient compliance with diet, medication regimen, and monitoring.
- “Coach” the patient to the next higher level of willingness to change with respect to diet changes, medication compliance, and monitoring.
- Examine feet; emphasize self-examination and foot care, skin care, and hygiene.
- Review general guidelines for nutrition in diabetes.
- Complete “SOAP: note (Subjective, Objective, Assessment, Plan) or “FARM” note (Findings, Assessment, Recommendations, Monitoring).
- Communicate pertinent patient encounter information/findings to primary care provider.

Please see **Attachment B1** for “**Standards of Care**” outline prepared by the data management entity - Medication Management Systems (MMS) and **Attachment B2 for “Patient Education Outline.”**

**Financial Component**  
(Flow of finances and reimbursement)

The ND Pharmacy Service Corporation will provide the initial start up money for the program with expectations of getting reimbursed on a bi-weekly basis to start. Reimbursement may need to be provided on a weekly basis as the programs moves forward. Every time a provider accesses and completes the required data entry documentation, a claim form is automatically created for processing based on the care/services provided. Providers will submit the claims to Medication Management Systems (MMS). MMS will forward a summary of claims to BC/BS of ND or Prime for payment to be sent to the ND Pharmacy Service Corporation. The ND Pharmacy Service Corporation will then issue reimbursement checks to the appropriate providers.

Flow: Providers – Medication Management Systems – BC/BS of ND – ND Pharmacy Service Corporation – Back to Providers.

The ND Pharmacy Service Corporation is offering their services at a “flat rate” of \$800 per participant enrolled in the program during the first year. The “flat rate” will cover costs associated with data management, travel, clinical coordinator, reimbursement to providers, and administrative costs associated with the program. It is anticipated that the “flat rate” per participant would drop per participant moving into the second year of the program. With the funding that is available, we anticipate the number of lives to be covered to be approximately 800 during the first year of the program. MMS is fully auditable and financial records will be kept and available for review by NDPERS, if and when requested.

The ND Pharmacy Service Corporation will develop infrastructure (network agreement) for contracting with pharmacists and other providers. This will be done through a network agreement form. The ND Pharmacy Service Corporation will contract

with a qualified provider to be the Clinical Coordinator of this program. The ND Pharmacy Service Corporation will also contract with a data management entity - Medication Management Systems (MMS).

The ND Pharmacy Service Corporation will also contract with the NDSU College of Pharmacy, Nursing and Allied Sciences to provide the educational and accreditation for pharmacists and other participating providers. The NDPERS group will issue an RFP for an independent consultant to evaluate and assess the program. NDPERS will also explore the option of having NDSU College of Pharmacy provide their expertise in data collection and analysis. NDSU has expressed interest in providing the data analysis and evaluation of findings for the program.

In working with BC/BS of ND, their role will be limited to waiving co-payments for program participants at the point of sale (flag them upon enrollment) or other feasible method. BC/BS will also identify potential participants by zip codes to provide the NDPSC with an outline of potential geographic participation.

BC/BS of ND will also have a role in providing pharmacy claim information for participants going back at least 12 months prior to the start of the program for comparison 12 months after enrollment begins. BC/BS will also receive a billing summary for services rendered and will issue a reimbursement check back to the NDPSC. This is an insurance company's typical role in working with disease state management vendors.

### **Expected Outcomes – Trends**

Success in this ongoing program is defined as improvement in glycosylated hemoglobin (A1C) concentration, continued program compliance, and improvements in other clinical areas. Success will also be defined based on increased patient satisfaction with provider services, and decreased costs of medical care for patients with diabetes. Please see **Attachment C** for a **listing of reports to be generated**.

### **Project Timetable/Timelines:**

- 1) August 31, 2007: Develop DSM concept proposal and submit to NDPERS.
- 2) September 2007 – Meet with NDPERS staff to review proposal
- 3) December 31, 2007 – Develop and submit “technical” proposal to NDPERS.
- 4) January 2008 - Meet with NDPERS Board of Directors to go over details of program before moving forward – provide presentation.
- 5) February 1, 2008 – Start to develop network of pharmacists and start to train pharmacists on diabetes care, blood glucose monitors and web-based documentation system.
- 6) April 1, 2008 – NDPERS will start to send notification to members regarding the availability of the program (target start date of May 1, 2008).
- 7) Through March 2008 – # 2,3, and 4 above will continue until initial enrollment date (target date of May 1, 2008).
- 8) May 1, 2008 – June 1, 2008 – test program - data collection.
- 9) July 1-31, 2008 – Advisory Board will be developed.
- 10) June 1, 2008 – June 30, 2009 – Implementation of program – roll out, data collection and analysis of data.
- 11) August 1, 2009 – Submit final report and continue into 2<sup>nd</sup> year of the program.

### **Description of the Qualification of Key Staff**

David J. Olig, R.Ph. is the pharmacy owner of Southpointe in Fargo. He is a graduate of North Dakota State University and is a practicing pharmacist. He has developed and implemented DSM programs in his pharmacies including asthma. He is the chairman of the North Dakota Pharmacy Economics Advisory Committee that has devoted considerable time to the passage of HB 1433 in the North Dakota Legislature. Dave is also the current Vice-President of the ND Pharmacy Service Corporation. He will continue to serve in a leadership capacity to organize and implement the project including the recruitment of pharmacists in the delivery of this program.

Dr. David Scott, Associate Professor of Pharmacy Practice, is the Director of the North Dakota Institute for Pharmaceutical Care. He earned his Bachelor of Science degree in Pharmacy and Ph.D. in Social and Administrative Pharmacy from the University of Minnesota in 1972 and 1987, respectively. He also earned a M.P.H. in Health Education and Interdisciplinary Studies at the University of Minnesota in 1982. He served on the faculty of the College of Pharmacy at the University of Nebraska Medical Center from 1986 to 2003. He has conducted investigations in the area of DSM, rural health, and outcomes research. Dr. Scott has been a PI on a previous AACP GAPS project on pharmaceutical-care training of pharmacists and served as the PI on the U.S. Department of Health and Human Services funded Siouxland Pharmacist Managed Diabetes Project. Dr. Scott has participated in numerous research studies and has more than 60 peer-reviewed publications and book chapters. In this project, Dr. Scott will be responsible for assessment and analysis of program data.

Howard Anderson, R.Ph., is Executive Director of the North Dakota Board of Pharmacy. He will assist the ND Pharmacy Service Corporation in the implementation of the overall project, including selection of the targeted communities, recruitment of pharmacy sites and licensed pharmacist store owners, and assurance that the DSM services delivered, the qualifications and training of the pharmacists, and the technology used for the project are in compliance with the Board of Pharmacy rules and regulations established for the State of North Dakota. He earned a Bachelor of Science in pharmacy from North Dakota State University in 1968. Since 1968 he has been a licensed pharmacist storeowner of Turtle Lake Rexall Drug in Turtle Lake, North Dakota.

Dr. Charles D. Peterson is Dean and Professor of the College. Dr. Peterson earned his Bachelor of Science in Pharmacy and Doctor of Pharmacy degrees from the University of Minnesota's College of Pharmacy in 1976 and 1977, respectively. He was hired by NDSU in 1989 as associate dean and Chair of the Department of Pharmacy Practice where he facilitated the development of the College's six-year entry level Doctor of Pharmacy degree program in 1990. Dr. Peterson has served as chair of the University's Institutional Review Board for the Protection of Human Research Subjects and as an evaluation team member for the American Council on Pharmaceutical Education, the accrediting agency for schools and colleges of pharmacy nationally. He has published over 50 peer-reviewed publications and has procured over \$9 million in grants and contracts as principal investigator (PI) from private, state, and federal funding agencies.

Dr. Tara Schmitz, Pharm. D. is an Assistant Professor, College of Pharmacy, Nursing, and Allied Sciences, North Dakota State University. She is the Director of Pharmacy Continuing Education. She obtained the Doctor of Pharmacy in 1995 from North Dakota State University. Areas of expertise include retail pharmacy practice (chain and independent), long-term care (provider and consultant), and pharmaceutical care. She teaches courses Pharmacy 351, 352, 451, 452 - Pharm Care Series I-IV. She is certified in DSM in cholesterol. Dr. Schmitz will coordinate the delivery of the home-site and clinical skills training components of the DSM training program for pharmacists.

Michael Schwab is Executive Vice President of the North Dakota Pharmacists Association and the ND Pharmacy Service Corporation. He assists the College of Pharmacy in the implementation of the overall telepharmacy project by serving as an Association liaison to the College and the State Board of Pharmacy. He earned a Bachelor of Science in social work from the University of Mary in Bismarck in 2001. Prior to his position with the NDPhA, he was the executive director for The Arc of Bismarck, a private, nonprofit disability advocacy, research and educational organization. He has received extensive training regarding public policymaking and legislative processes at state and federal levels. He has been a registered lobbyist in ND for the past 4 legislative sessions. He has worked with the ND Department of Human Services and CMS on collaborative projects, including the implementation of legislation.

Clinical Coordinator - Job Description Outline – See **Attachment D** – Position will be filled by March 2008.

### **Background on Proposing Organization**

The ND Pharmacists Association (NDPhA) was organized in 1885. NDPhA is a private non-profit organization located in Bismarck, ND. The mission for the profession of pharmacy in ND is as follows: Pharmacy in ND exists as a force in society for the safe, rational, and cost effective use of pharmaceuticals and medical devices. Through the provision of pharmaceutical care, the profession is responsible for the appropriate use of medications and devices to achieve the optimal therapeutic outcomes. The profession endeavors to enhance the pharmacist's ability to provide pharmaceutical care as a primary health care provider and to further the public's recognition of the profession's value. NDPhA values: (1) service; (2) ethics; and (3) professional competence. NDPhA envisions a profession that is recognized as a primary health care provider capable of responding to society's health care needs. As the professional society representing pharmacists in the state, the objectives of the NDPhA are to act as the leader: (1) advocating the role of the pharmacist as an essential provider of health care; (2) to support pharmacists in providing optimal pharmaceutical care; (3) to encourage and assist pharmacists to use profitable methods to add value to their pharmacy knowledge base; and (4) by working to improve pharmacists' services and delivery of products needed by health care consumers.

NDPhA represents over 700 hundred licensed pharmacists throughout the state and cover all practice settings. NDPhA is made up of community pharmacists, health-system pharmacists, pharmacy technicians and various associate memberships. NDPhA has a Board of Directors that over see all operations and activities of the Association. The ND Pharmacy Service Corporation (NDPSC) is a wholly owned subsidiary of the NDPhA. The NDPSC is made up of over 100 pharmacy owners throughout the state. The NDPSC has its own Board of Directors and operates under the umbrella of NDPhA. The NDPSC Board of Directors consists of one Director from each of the 8 Districts of the NDPhA and the Association's President.

The purpose of the NDPSC is to form a network of pharmacies in ND that can provide services for, governmental agencies, employer groups, educational entities, and

members of the public. NDPSC works to negotiate incentive programs that provide new opportunities through pharmacy practice concentrating on wellness and prevention.

Some of the main activities the NDPhA and the NDPSC are involved with include but limited to: (1) collaborative partner in a statewide run “telepharmacy” network in partnership with the North Dakota State University – College of Pharmacy, Nursing and Allied Sciences and the ND Board of Pharmacy; (2) network and collaborate with the ND Department of Health and Human Services on various initiatives; (3) promote and encourage a Pharmacy Quality Commitment Program; (4) work to improve health outcomes for patients through medication therapy management services; and (5) provide individual and systems advocacy efforts on local, state and federal levels on behalf of patients, pharmacists and communities. National and State organizations we are involved with include but not limited to: (1) ND Diabetes Coalition; (2) ND Rexall Club; (3) ND Institute on Pharmaceutical Care; (4) Mid-West State Executives Alliance; (5) National Alliance of State Pharmacy Associations; (6) National Community Pharmacists Association; (7) American Society of Health-System Pharmacists; and (8) ND Health Information Technology Steering Committee.

### **Identification and Role of Subcontractors**

Initially, the NDPSC will enter into two subcontracts. One contract with Medication Management Systems and one contract for clinical coordinator services will be executed prior to March 1, 2008. Please read subcontractor’s information listed below.

Medication Management Systems (MMS): MMS is a Minnesota-based company whose technology-based system delivers the support and resources providers need to be reimbursed for medication therapy management services when providing pharmaceutical care services to patients. The company’s Assurance System<sup>TM</sup> includes a comprehensive documentation process that automatically generates billing information in the required format, provides practitioner training, practice management, computer system support, practice outcomes reporting, and secure 24-hour online access. Over 35,000 patients have been cared for with this system and over 80,000 interventions have been documented.

Some of the features of the Assurance System™ include:

- Building a Patient Electronic Therapeutic Record
- Identifying, Tracking and Resolving Drug Therapy Problems
- Creating Custom Patient Care Plans and Care Protocols
- Documenting and Reporting Patient Therapeutic Goals
- Demonstrating Clinical Outcomes and Economic Benefits
- 150 Custom Practice Evaluation and Management Reports
- Integrated Disease State Management Modules

MMS is the leader in designing, implementing and integrating successful, standards-driven medication therapy management programs in any practice setting, from solo practitioners, provider networks, health systems and call centers. Their program, measured by performance criteria, improves medication efficacy, safety, and adherence through service, technology, data, and outcomes.

Clinical Coordinator Position: The NDPSC will enter into a contract for clinical coordination services of the program. This will be executed prior to March 1, 2008. Job description outline is provided in Attachment D.

### **Project Progress Reports**

Ultimately, the employer can decide how often they would like to be provided with an update. Program Clinical Coordinator will be the individual providing the update. We anticipate progress reports or project status to be provided at least quarterly. In addition to the quarterly progress reports, a “full” report will be generated after 12 months of operation. Project progress reports will be shared at NDPERS Board meetings and/or with the Executive Director of NDPERS and other appropriate program partners. The employer ultimately can decide how often reports are to be generated.



## **Attachment A**

### **Pharmacist Diabetes Management and Accreditation Program Schedule**

#### **Friday**

8:00 AM	Welcome and Pre-test
8:30 AM	Diabetes overview/complications
10:30 AM	Pharmacotherapy treatment/Diabetes cases
12:30 PM	Lunch
1:30 PM	Pharmaceutical Care plans for patients with diabetes
3:00 PM	Documentation, collaborative practice agreements, pharmacy interventions, reimbursement
4:30 PM	Planning and implementing your program: marketing/action plans
6:00 PM - on	Open - Pharmacists networking

#### **Saturday**

8:00 AM	Assessment and education of the patient with diabetes
10:00 AM	Insulin devices and injection skills training
11:00 AM	Glucose self-monitoring blood glucose meters/strips skills training
12:30 PM	Lunch
1:30 PM	Diabetes skills building cases: assessment and education of patients
4:00 PM	DSM session
5:00 PM - on	Post-test and Evaluation
6:00 PM	Adjournment

## **Attachment B1**

### **STANDARDS FOR THE SERVICE**

The service delivered by providers will adhere to the following care standards. All patient encounters will be documented and recorded in the Assurance System™.

#### **STANDARDS OF CARE PRACTITIONERS**

<b>Category</b>	<b>Standard</b>
I. Assessment	<p>1. The practitioner collects relevant patient-specific information to use in decision-making concerning all drug therapies.</p> <p>2. The practitioner analyzes the assessment data to determine if the patient's drug-related needs are being met, that all the patient's medications are appropriately indicated, the most effective available, the safest possible, and the patient is able and willing to take the medication as intended.</p> <p>3. Identification of drug therapy problems: The practitioner analyzes the assessment data to determine if any drug therapy problems are present.</p>
II. Care plan development	<p>4. The practitioner identifies goals of therapy that are individualized to the patient.</p> <p>5. The practitioner develops a care plan that includes interventions to: resolve drug therapy problems, achieve goals of therapy, and prevent drug therapy problems.</p> <p>6. The practitioner develops a schedule to follow-up and evaluates the effectiveness of drug therapies and assesses any adverse events experienced by the patient.</p>
III. Follow-up evaluation	<p>7. The practitioner evaluates the patient's actual outcomes and determines the patient's progress toward the achievement of the goals of therapy, determines if any safety or compliance issues are present, and assesses whether any new drug therapy problems have developed</p>

### Standard of Care 1: Collection of Patient-specific Information

The practitioner collects relevant patient-specific information to use in decision-making concerning all drug therapies.

#### Measurement criteria

1. Pertinent data are collected using appropriate interview techniques.
2. Data collection involves the patient, family and caregivers, and health care providers when appropriate.
3. The medication experience is elicited by the practitioner and incorporated as the context for decision-making.
4. The data are used to develop a pharmacologically relevant description of the patient and the patient's drug-related needs.
5. The relevance and significance of the data collected are determined by the patient's present conditions, illnesses, wants, and needs.
6. The medication history is complete and accurate.
7. The current medication record is complete and accurate.
8. The data collection process is systematic and ongoing.
9. Only data that are required and used by the practitioner are elicited from the patient.
10. Relevant data are documented in a retrievable form.
11. All data elicitation and documentation is conducted in a manner that ensures patient confidentiality.

### Standard of Care 2: Assessment of Drug-related Needs

The practitioner analyzes the assessment data to determine if the patient's drug-related needs are being met, that all the patient's medications are appropriately indicated, the most effective available, the safest possible, and the patient is able and willing to take the medication as intended.

#### Measurement criteria

1. The patient-specific data collected in the assessment are used to decide if all of the patient's medications are appropriately indicated.
2. The data collected are used to decide if the patient needs additional medications that are not presently being taken.
3. The data collected are used to decide if all of the patient's medications are the most effective products available for the conditions.
4. The data collected are used to decide if all of the patient's medications are dosed appropriately to achieve the goals of therapy.
5. The data collected are used to decide if any of the patient's medications are causing adverse effects.
6. The data collected are used to decide if any of the patient's medications are dosed excessively and causing toxicities.
7. The patient's behavior is assessed to determine if all of his/her medications are being taken appropriately in order to achieve the goals of therapy.

### Standard of Care 3: Identification of Drug Therapy Problems

The practitioner analyzes the assessment data to determine if any drug therapy problems are present.

#### Measurement Criteria:

1. Drug therapy problems are identified from the assessment findings.
2. Drug therapy problems are validated with the patient, his/her family, caregivers, and/or health care providers, when necessary.
3. Drug therapy problems are expressed so that the medical condition and the drug therapy involved are explicitly stated and the relationship or cause of the problem is described.
4. Drug therapy problems are prioritized, and those that will be resolved first are selected.
5. Drug therapy problems are documented in a manner that facilitates the determination of goals of therapy within the care plan.

### Standard of Care 4: Development of Goals of Therapy

The practitioner identifies goals of therapy that are individualized to the patient.

#### Measurement Criteria

1. Goals of therapy are established for each indication for drug therapy.
2. Desired goals of therapy are described in terms of the observable or measurable clinical and/or laboratory parameters to be used to evaluate effectiveness of drug therapy.
3. Goals of therapy are mutually negotiated with the patient and health care providers when appropriate.
4. Goals of therapy are realistic in relation to the patient's present and potential capabilities.
5. Goals of therapy are attainable in relation to resources available to the patient.
6. Goals of therapy include a timeframe for achievement.

### Standard of Care 5: Statement of Interventions

The practitioner develops a plan of care that involves interventions to resolve drug therapy problems and interventions to achieve goals of therapy.

#### Measurement criteria:

1. Each intervention is individualized to the patient's condition, needs, and drug therapy problems.
2. All appropriate therapeutic alternatives to resolve the drug therapy problems are considered, and the best are selected.
3. The plan is developed in collaboration with the patient, his/her family and/or caregivers, and health care providers, when appropriate.
4. All interventions are documented.
5. The plan provides for continuity of care by including a schedule for follow-up.

### **Standard of Care 6: Establishing a Schedule for Follow-up Evaluations**

The practitioner develops a schedule to follow-up and evaluates the effectiveness of the outcomes from drug therapies and assesses any adverse events experienced by the patient.

#### **Measurement criteria:**

1. The clinical and laboratory parameters to evaluate effectiveness are established, and a timeframe for collecting the relevant information is selected.
2. The clinical and laboratory parameters that reflect the safety of the patient's medications are selected, and a timeframe for collecting the relevant information is determined.
3. A schedule for the follow-up evaluation is established with the patient.
4. The plan for follow-up evaluation is documented.

### **Standard of Care 7: Follow-up Evaluation**

The practitioner evaluates the patient's actual outcomes and determines the patient's progress toward the achievement of the goals of therapy, determines if any safety or compliance issues are present, and assesses whether any new drug therapy problems have developed.

#### **Measurement Criteria:**

1. The patient's actual outcomes from drug therapies and other interventions are documented.
2. The effectiveness of drug therapies is evaluated, and the patient's status is determined by comparing the outcomes within the expected timeframe to achieve the goals of therapy.
3. The safety of the drug therapy is evaluated.
4. Patient compliance is evaluated.
5. The care plan is revised, as needed.
6. Revisions in the care plan are documented.
7. Evaluation is systematic and ongoing until all goals of therapy are achieved.
8. The patient, family and/or caregivers, and health care providers are involved in the evaluation process, when appropriate.



Diabetes Disease State Management Services NDPhA

## Program Design

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The Diabetes Disease State Management program is designed to incorporate patients with diabetes and health care professionals to receive the education and support necessary to comprehend the basic pathology of DSM; its natural history, consequences, preventive measures and the coping skills necessary to work with the disease. This program is intended to introduce risk-modifying behaviors for all afflicted or at-risk patients including but not limited to diet, exercise, and cholesterol control, the proper use of oral and injectable medications. It reviews and encourages the self and medical monitoring of blood glucose levels to achieve better control. The program is designed to improve the patient's self-management skills and ability to navigate in a health care delivery system. The program is intended to be tailored to the patient and may include the items listed below. Patients in the program will have a minimum of four visits with health care professionals trained in Diabetes to provide education and monitoring of glucose levels, weight, blood pressure, cholesterol and other indicators.

### **Self-monitoring blood glucose**

- Set blood glucose goals
- Learn to use a meter for accurate results
- Follow a monitoring schedule
- Interpret blood glucose values
- Make treatment plan decisions based on values
- Clean and maintain the meter
- Store supplies

### **Insulin or diabetes medications**

- Understand actions and side effects of medication
- Correctly follow medication timing and dosing schedule
- Demonstrate proper insulin injection techniques
- Follow an injection site rotation schedule
- Properly store, refrigerate, and dispose of supplies
- Know what to do if you miss a dose

### **Sick day management**

- Prevent life-threatening problems during illness
- Know what to eat and drink
- Adjust glucose monitoring and medication schedules
- Know when to call the doctor

### **Exercise**

Follow exercise guidelines for length, intensity, interval, and timing of workouts adjust snacks for exercise levels to prevent high and low blood sugar when exercising.

### **Knowledge of blood sugar levels**

- Understand causes of blood sugar fluctuations
- Recognize symptoms of high or low blood sugar
- Follow proper treatment guide-lines for sugar imbalance
- Work to prevent sugar imbalance
- Know when to call a doctor

### **Meal planning skills**

- An overview of meal planning will be discussed with participants
- Participants will be referred to dieticians and nutritionists when appropriate or requested

### **Foot care**

- Follow daily foot care guidelines
- Know emergency treatment for cuts, sores, scrapes
- Practice self-examination of feet
- Select and use proper footwear

### **Urine testing for ketones (insulin-dependent diabetes)**

- Know when and how to check for ketones
- Understand what it means when ketones are present
- Know when to call the doctor

**The following will be included in the educational process with participants and appropriate referrals will be made to the participant's primary care provider.**

- Hemoglobin A1c (2 to 4 times/year)
  - Kidney function (microalbumin)
  - Cholesterol, LDL, HDL, and triglycerides
  - Foot exam
  - Eye exam
  - Blood pressure
  - General health exam
  - Review diabetes management skills, including
    - Meal plan
    - Skills in taking medication
    - Glucose monitoring technique
    - Treating high or low blood sugar
    - Sick day management
    - Risk factors for health care problems
-



### **QUARTERLY REPORTS**

The following reports will be generated for the Program (unless directed otherwise):

#### **Patient Reports**

- Number of patients served.
- Number of total patient encounters.
- Distribution of ages of patients served.
- Distribution of gender of patients served.
- Complexity of patients served as determined by number of conditions, drug therapy problems, and medications.

#### **Medical Conditions Reports**

- Frequency of number of medical conditions by patient being treated or prevented with drug therapies
- Most frequent indications for drug therapy encountered by practitioners.

#### **Medication Reports**

- Frequency of number of drug therapies by patient.
- Distribution of source [prescription, OTC, sample, friends/family] medications used by patients.
- Drug therapy problem reports (compliance).
- Number and percent of patients with drug therapy problems.
- Total number and distribution of drug therapy problems identified and resolved by practitioners.
- Causes of drug therapy problems identified and resolved.
- Drugs associated with drug therapy problems.
- Medical conditions of drug therapy problems.
- Interventions applied to resolve drug therapy problems.

#### **Clinical Outcome Reports**

- Clinical outcomes of all patients served.
- Clinical outcomes of patients treated for specific medical conditions.
- Distribution of patients who achieved goals of therapy after receiving services.
- Number and percent of patient whose clinical condition improved and those who remained stable after receiving service.
- Referrals as interventions to other providers.

#### **Economic Outcome Reports**

- Drug cost avoidance resulting from services provided.
- Health care cost avoidance resulting from services provided.
- Number of emergency department visits avoided as a result of providing services.
- Number of urgent care visits avoided.
- Number of office or medical clinic visits avoided.
- Number of hospitalizations avoided.

## **Attachment D**

### **Clinical Coordinator Position**

#### **Basic Functions and Responsibilities:**

- Champions the principles of pharmaceutical care in drug therapy management
- Ensure strict compliance with all standardized professional policies and procedures
- Mentoring of pharmacists and pharmacy management team to increase their clinical effectiveness and counseling skills
- Recruit Pharmacists and other possible providers
- Work with employer (in this case BC/BS) to set up appropriate billing for pharmacists fees
- Notify employer/PBM of appropriate providers
- Maintain the highest HIPPA standards possible.
- Assure that employer/PBM have a method for flagging participating patients in their systems
- Work with employer/PBM to set up waiver/reduced co-payments for medications
- Contact person for information on the program
- Work with employer/PBM to arrange for needed reports
- Work with employer/PBM to promote program
- Notify employer/PBM of patient's enrollment
- Point person for resolving billing problems (Example: patients being billed for things that should be covered)
- Coordinate lab testing, when appropriate
- Track outcomes and work with the College of Pharmacy (NDSU) regarding the statistical significance/analysis or outcomes
- Present and publish findings
- Other duties as assigned

#### **Experience Guidelines and Leadership Competencies:**

- B.S. Pharmacy or Pharm. D. with licensure. Advanced degree helpful but not required
- Highly motivated and resilient professional
- Demonstrated leadership and supervisory skills
- Strong clinical decision-making skills
- Grant writing experience
- Excellent communications skills (verbal and written) and scientific writing skills
- Strong presentation skills
- Strong critical-thinking/problem solving skills

- Demonstrated ability to balance economic, business and operational factors with care responsibilities
- High professional ethics and standards
- Strong team player and team building skills
- Ability to collaborate with all levels and areas
- Proven relationship-building and management skills
- 3-5 years clinical experience preferred, but not required

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